For a meaning of human suffering: the paradigm of abyss

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Abstract
The purpose of this article is to explain a new theoretical paradigm about expressions and interpretation of human suffering, with using psychoanalytic instruments and theories. So the author will examine the different connotations of suffering, paying more attention to the components from which it is composed, that is the parameters used to describe it. Of course, the authentic meaning of suffering does not correspond to a simple absence of well-being of the psychic apparatus: quite the opposite, pain produces psychic work. So it will be far from the author's intentions to insert the object of the argument in a reductionist point of view (the suffering as a sort of psychic nociception) or in cartesian point of view (suffering as resulting from a cause/effect connections). The meaning - mentioned in the main title - is given by the subject to his difficult “art of living”.

Key words: Italian psychoanalysis; suffering; metapsychology; organizations of personalities.

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Introduction

The word “pain” can easily be connected to the traditional dichotomy between physical pain and psychic pain. In fact, it arises very easily - to associate them and insert them in a mutual exclusion prospective, but actually it makes up a mistake as approximate as harmful. First of all, such a reductionist point of view - I would say cartesian - of pain entails to refuse the psychosomatic unity, constituting man himself, that is the denying the bond of mutual influence that exists between body and mind. After all, how could body sublimation processes, such as conversion and somatization, be explained? In other words, a mind-body dichotomy can easily be put in check without any particular theoretical intervention, especially if we consider the authentic suffering, that everybody lives or has lived in his own life. Suffering is evolutionary: it has promoted the evolution of the species, the adjustment with the environment and psychic work. As Weiss(1932) suggests, the body and the psychic apparatus are intrinsically connected in the experiences of joy, sorrow, pain, enjoyment and suffering: in other way to say they are part of a "metapsychology of pain"(Semi, 2003), because these experiences are mainly linked by economic aspects, that is energy processes. In fact, was it not already present in Freud's intent to describe a concept - the drive - that was placed between the psychic and the somatic? Well based on what Weiss suggests: in dreams is the sensation of pain real or fictitious? It's real, of course! In the psychoanalytic tradition, suffering occupies an extremely relevant position, both from a theoretical point of view and consequently from a therapeutic point of view, as it was the first science to visualize the profound correlation between psychic suffering and physical suffering; for example we can see it in the hysterical compliance of some organs in the broad spectrum of psychoneuroses or sadism or sexual masochism! In other words psychoanalysis suggests a monistic definition of suffering, in which contrasting and heterogeneous elements converge. There are different types of psychic suffering - in many cases bordering on somatic suffering - and it’s right to ask which are the boundaries between them, assuming that they - the boundaries – actually exist or assuming that it’s even necessary to theorise them. However, we must first provide a definition of suffering, from which to start weaving the first network of meanings. Suffering can be defined as the quali-quantitative dimension of a series of parameters - symbolization, object relationship, defenses and anguish(in a psychoanalytic sense of meaning) - which work at a different and variable level and mixed in a heterogeneous way. Questioning ourselves about suffering involves collaterally questioning about the resources available to the subject and above all how the resources are used. This leads us to analyse the subject's personality organization, because as the psychic organization of the subject changes, the manifestation and processing of suffering change.

The axioms of suffering and the quali-quantitative approach

Even before a mode of functioning or a psychic affection there is always a state of suffering in effect. In fact, suffering as such - not to be confused with a sort of psychic nociception - constitutes a sort of amalgam of mental diseases, that is, a complex and a mixture of heterogeneous and sometimes contrasting elements. There are three macro-categories of suffering, namely neurotic, borderline and psychotic, each of which has specific characteristics. Please refer to the following paragraph for a more complete discussion of them. Anyway it was possible to recognize five main axioms that regulate the action and manifestation of suffering:

1. it constitutes a qualitative aspect of psychic functioning, although quantitative aspects always intervene, in other words the quality of
suffering (the typology: neurotic, borderline and psychotic) is given by quantitative factors (please see tab 1). So suffering at the same quality is always differentiable;

2. the quality of the suffering may not be congruous with the dominant organization, therefore a psychotic suffering (for example a sorrow for a very important person) can break into a neurotic functioning;

3. suffering differs from anguish, because the first one is also a conscious and preconscious phenomenon. In fact, it has a cognitive (conscious) side. Furthermore, anguish is more of a component of suffering;

4. it involves a qual-quantitative approach;

5. the typology of suffering can determine the psychic functioning and their destinies, in fact suffering promotes psychic work: it qualifies both autoplastic and alloplastic phenomena.

These axioms constitute the *sine qua non* condition of this theoretical model. It seems necessary to explain more adequately the aspects of the model concerning the qualitative-quantitative approach, especially with reference to the personality functions, which constitute the container of suffering. Why is the connection between suffering and personality organization necessary? Such connection is necessary, because in the act of explaining suffering we have to take into account economic factors, namely related to the economy itself of the psychic organization. A theoretical model, which has as its objective to explain a clinical phenomenon, cannot be devised on an excessively rigid and peremptory methodological system, because it would be too naive and artificial compared to the patient's symptomatic uncertainty; in other words it would be a mistake, that excludes the subjectivity and the clinical history of patient from the diagnostic process. It alludes to qualitative models, which risk overlapping the patient and his symptoms. Personality functioning, although it refers to a quality of psychic organization, implies that the clinician adopts a quantitative perspective, because two subjects with the same functioning show at the same time analogies but also substantial differences. The idea that moves the author's hand is to suggest a qual-quantitative approach, especially if we consider that personality functions - along a continuum - always imply a qualitative data after a quantity data. For example: the subject uses a repression which is a mechanism concerning neurotic functioning. This is the qualitative data, which suggests the level of organization of the patient at a specific moment. To which extent does he use this mechanism? The answer to this question will be the quantitative data, which indicates the level of dysfunction of the mechanism, that is, it suggests the positioning of the patient on a level of functioning and impairment (psychopathology). After all, it’s the quantitative aspect that differentiates the different functionings of psychism. Of course, the qualitative data is only a heuristic index, that must be subordinated to the quantitative one; in fact, with no a quantitative dimension it ends up being more of a distractor than a useful indicator for the investigation. The qualitative model of the diagnostic investigation finds its crowning glory in the descriptive nosography, far from the quantitative logic of the psychoanalytic model. However, placing the qualitative and quantitative model as a dichotomy can involve some risks, because it cannot be denied that there is also a qualitative difference between patients. Taking this into account can only improve the investigation of the patient’s different symptomatological domains. Furthermore, we can imagine the aforementioned approaches as two vectors, that intersect reciprocally at two points, forming three organizational spaces, in
reference to personality functionings. This vector arrangement can be applied to all psychic phenomena that need a double approach, for example defense mechanisms. Another objective of the discussion is to overcome the umpteenth dichotomy imposed by the theoretical families that oppose each other for differences, while neglecting the analogies. Certainly the author’s idea, although he prefers a quantitative approach to psychopathology, as more suited to Psychoanalysis and the Clinic, is animated by the need to subject to critical examination even what may appear to be further from one’s own theoretical reference system, in this case the qualitative approach. So integrating the latter does not mean neglecting the first one: quite the opposite it can only enrich the theoretical corpus of departure, showing aspects, that until that point perhaps have gone unnoticed.

Understanding the patient’s suffering involves having mobile and economic coordinates: reference parameters, that do not overwrite the patient. So the clinician must be careful in not doing a squaring of the circle. The qualitative approach - deprived of quantity - is appeared in the nosographic-descriptive methodology, that is - in this case - a form of a labeling. From this point of view, nosography ends up becoming a lifesaver-tautology, in which only the clinician is saved from his misunderstanding of the his patient.

Picture 1 - The image shows the vector of quantity intersecting twice with that of quality; in the case of personality functioning, vectorization is the present as showed. Along the vertical axis (quantity) we place the processes that define the prevalence of this or this other functioning, on the horizontal axis (quality) we place the use - stationary in one functioning - of the same processes. For example, projective identification can be used in both neurotic and borderline operations. The difference is the amount of using it. When the organization stops at a single operation, the qualitative factor takes over, which designates the type of suffering to be processed. In other words, the qualitative and quantitative approach intersect each others at the breaking points of the functionings, in which the quantity suggests the type of organization and the quality the type of suffering. Therefore a neurotic functioning may face a psychotic suffering. What will happen? The functioning with its mechanisms manages to metabolize this suffering, the functioning is configured in a psychotic way or, when these two cases do not occur, a psychotic moment comes into play (Balsamo, 2014). In any case, clearly quantitative factors underlie suffering: its qualitative aspect is only heuristic.

A kinetic model of suffering

The kinetic model refers to the continuous oscillations of human suffering, which by its nature does not always remain the same at itself due to a series of variables not only of a
strictly psychic nature, but it tends to change
due to the effects of anthropological, cultural
and corporate phenomena. Naturally the
model does not allude to a definition of
suffering intended as a melting point, in
which variables of different nature converge,
rather it alludes to a way of existing,
considering that man is the only animal that
sets his existence as a problem. The
parameters used to describe human suffering
are basically four: mentalization
(symbolization), object relationship, anguish
and defense mechanism. The subdivision
of the parameters is proposed for a purpose of
explanation, in order to facilitate the
understanding and to streamline it from an
excess of information. In the clinic these are
obviously mixed. On the other hand, the link
of mutual implication can be understood
between the parameters, that is, it is always
difficult to establish the beginning of one and
the other; in fact, it is no coincidence that the
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approach. Mentalization is used as a synonym
of symbolization. It alludes to all the
capacities of making in the sense of trauma.
Symbolization more specifically indicates the
ability to translate lived experiences into
psychic content. It indicates "[...] an indirect
and figurative way of representing an idea, a
conflict, an unconscious desire" (Laplanche
J., Pontalis J.-B., 1967). Therefore, from a
psychoanalytic point of view, every substitute
representation is the result of symbolization,
including logically also the patient's
symptoms. An example is the spool game
(Freud, 1920), in which the little Ernst
attributes to the spool the representation of an
absent object and the relationship with the
latter. Consequently, suffering is linked to
everything that escapes symbolization
processes, because - in line with the Kleinian
lesson - it allows the use of an internal object,
when this is absent (we would say the
mother's breast for the baby). In fact,
subjectivity arises from the encounter
between the instinctual motions and the
external reality, an encounter conveyed by the
origins of symbolization processes. As
Lacan's studies suggest, language is one of the
main witness of symbolization skills.
Furthermore, what eludes symbolization - a
fact that can appear in multiple ways with
different outcomes - involves a first repetition
of the trauma; the repetition is an attempt to
make sense. On the other hand, the Freudian
lesson is very clear in this sense: we repeats
the trauma to not remember. Suffering is
shaped by the economy of the organization of
psychism, so making sense of trauma means
using resources economically equivalent to
the suffering in effect. This is the reason why
it was necessary to draw on a qualitative-
quantitative model approach. In fact, isn't the
trauma itself a quantitative experience? The
modalities of relationship with the object
indicate the set of psychic actions performed
by the subject towards the affective object,
defined according to a triplicity of definitions:
the object as a goal of the drive (phantasmic
object), as a correlate of the affects (love and
hate) and real external object, endowed with
properties independent of the subject.
Specifically, the relationship with the object
suggests whether the Oedipus has allowed a
separation between the Self and the other
people and therefore if there is a sense of
otherness in the subject. Analyzing the
patient's suffering means - at least indirectly
-questioning ourselves about his personality
functioning. The defense mechanisms are
intrinsically linked to the ways of relating to
the object, considering the defenses not only
resources against distress, but also as a way in
which the subject relates to the object.
According to an intersubjective perspective,
the object is not simply an object of pleasure
or displeasure (a destination for drive
investment), actually it corresponds - as
Roussillon suggests - to an object-other-
subject. So in the object relationship we can
see the degree of alterity in the subject. For
example: we observe the projective
identification used by the infants when it orbits the Ps position. What does he do? He polarizes the object for good or bad and he tends to attack it. Of course in this case I add saying that the bad object also arises from the need to spend the death drive, but this does not exclude what has been stated, because it is always a drive destination. Anguish derives from drive motions, therefore it has a "signal function" (Ferrant, 2007, 2018). It involves not only the intervention of economic factors, but also it indicates an emotional symbol of an anticipated situation to be avoided (Laplanche J., Pontalis J.-B., 1967). As Freud (1925) suggests, anguish is an attribute of the Ego. The conceptual reference of anguish corresponds to Freud's second theory of anguish, although the mechanisms of defense and anguish haven't always a linear relationship in the clinic. In the tab. 1 the different types of suffering are schematized according to the respective characteristics for each of the chosen parameters.

Conclusions

At the conclusion, the starting objectives seem at least partially achieved, considering that human suffering by its nature escapes any attempt to qualify it. This applies only if a disjunctive or preferentialist analysis paradigm on the aut-aut type is adopted (a positivist and nosographic-descriptive point of view). It would be a methodological error, because it would tend to pathologize and therefore reduce human suffering to the described terms. It would simply be absurd. On the other hand, the goal of a therapy in Psychology is first of all to increase the patient's thinkability about his trauma and in the Clinic we obviously start from the most authentic aspect, brought by the patient, that is his suffering! So visualizing suffering means starting to give back something to the patient about his morbid state. A psychotherapeutic path - which is worthy of this appointment - is painful and it involves adding complexity to complexity. The symptom can be placed in the relationship between the type of suffering and the functioning of personality, so illness is what is not understood about oneself. A reductionist theoretical model would be extremely inadequate and inconclusive in the act of explaining human behavior, especially if it is induced by a state of suffering, and Psychology would be faced with an excessively steep and tortuous road, if it were not for the indications that indicate the road to Hyperuranium. So what to do? Psychology has chosen the onerous task of building a new road, whose destination - as in all great journeys - coincides with the traveled road. If molecules of our body obey the laws of physics and chemistry, why are human minds and behavior so unpredictable? Perhaps there is an equation for each of us; it is right, but not entirely: the variables would be too many and unique for each individual, it avoids any attempt at generalization. If human suffering or behavior were such and determined by a single equation, we could say that free will does not exist, because it would be the result of a general and universal law. In reality and especially in the clinic we know that this is not the case. If the fate of men will perhaps one day be to explain the Universe, they will certainly never come to explain themselves and this is the heavy task of Psychology: to be the science of what is not understood. In reality and especially in the clinic we know that this is not the case. If the fate of men will perhaps one day be to explain the Universe, they will certainly never come to explain themselves and this is the heavy task of Psychology: to be the science of what is not understood. In reality and especially in the clinic we know that this is not the case. If molecules of my body obey the laws of physics and chemistry, why doesn't the human will to not suffer does not act like the orbit of a planet or like the watercourse in a waterfall? If the symptom is a compromise with disease, that is an attempt at self-healing, suffering is the compromise with existence, an existence that tends towards emptiness because of the disease. However, human suffering reminds us that even emptiness has a bottom.
Table 1. A conceptual reference with which to orient oneself in the analysis of the different sufferings of the patient, especially if we consider that suffering can constitute an index about the resources and dysfunctions of the patient's psychic economy.

<table>
<thead>
<tr>
<th>Suffering typology</th>
<th>Symbolization</th>
<th>Object relationship</th>
<th>Anguish</th>
<th>Defense mechanisms</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Neurotic suffering</strong></td>
<td>It is sufficiently intact and it allows to symbolize the conflict despite suffering.</td>
<td>The object is loved and feared at the same time. The Oedipus has allowed a separation between the Self and the other. Otherness is maintained. In other words, the object is total.</td>
<td>Predominantly castration anxiety with respect to the narcissistic investments of the patient: from the penis it moves to other psychic domains.</td>
<td>Mainly mature defenses. In this case, mechanisms such as removal and movement are preferred. The swinging between the Ps and D position is allowed.</td>
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<tr>
<td><strong>Borderline suffering</strong></td>
<td>It is compromised above all on the subjectivizing side (sense of reality and ego integration). However insights can sometimes be promoted and thinkability increased whenever possible it tends to polarize reality</td>
<td>It amplifies a dyadic conflict and a choice of object for support. Therefore, autonomy and separation from the object are sought at the same time (separation-identification process not successfully concluded). The object is split.</td>
<td>There are tendentially anguishes of abandonment, which derive from a fusion with the object, that absorbs the Ego, and from a separation from it, which would cause a violent abandonment.</td>
<td>It is used in a heavy way the identification projective, the splitting and the denial. The patient is stationary at the Ps position.</td>
</tr>
<tr>
<td><strong>Psychotic suffering</strong></td>
<td>It is seriously compromised due to the action of the rejection (“Verwerfung”). The conflict cannot be represented and the suffering is overflowing. The exam of reality is compromised.</td>
<td>State of total fusion with the object: loss of boundaries between self and the outside. So the perceived object coincides with the real object.</td>
<td>Primitive anguishes such as those of annihilation, fragmentation and emptying, which presupposes an envelope and cape-object (Ferrant, 2007, 2018). Frustration is intolerable. Anguishes constitute nameless terror (Bion, 1967).</td>
<td>The defensive configuration is practically bankrupt and inefficient. The patient tries to use psychotic denial, idealization, omnipotence, splitting, projective identification and acting out. Depressivity is inoperative.</td>
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References